AFFIDAVIT

JAMES MCDONALD #236354
PLAINTIFF

VS. **CIVIL ACTION NO. 06-284-MHT**

DEFENDANTS.

RICHARD ALLEN, et.al.

STATE OF ALABAMA
EASTERLING CORRECTIONAL FACILITY

I, Kay Wilson, hereby certify and affirm that I am a Health Services Administrator at Easterling Correctional Facility; that I am one of the custodians of inmate medical records at this institution; that the attached document(s) are true, exact, and correct photocopies of certain documents maintained here in the Health Care Unit – Easterling C.F.; and that I am over the age of twenty-one years and competent to testify to the aforesaid documents and matters stated therein.

I further certify and affirm that said documents are maintained in the usual and ordinary course of business at the Easterling Correctional Facility; and that said documents (and the entries therein) were made at, or reasonably near, the time that by, or from information transmitted by, a person with knowledge of such facts, events, and transactions referred to therein are said to have occurred.

This, I do hereby certify and affirm to on this the 22nd day of August, 2006.

Kay Wilson

SWORN TO AND SUBSCRIBED BEFORE ME THIS THE 22nd DAY OF August, 2006.

My Commission Expires: 7-15-07

Linda E. [illegible]
NOTARY PUBLIC

EXHIBIT
B

AL DEPARTMENT OF CORRECTIONS

RADIOLOGY SERVICES REQUEST AND REPORT

INSTITUTION: Easterling

Name: Mr. Donald James

State ID No: 236354

DOB 3/22/68

Race: W Sex: M

NOTE: PERTINENT CLINICAL INFORMATION AND TENTATIVE DIAGNOSIS MUST BE PROVIDED FOR X-RAY EXAMINATION TO BE PERFORMED

Requesting Physician/PA/NP	Date of request	Time of request	Routine	Priority	Transportation or special needs
Dr Darby	6/29/06	1:15 pm			

HISTORY/DIAGNOSIS:

X-RAY REQUEST

	ABDOMEN/KUB	L	FINGERS 3rd Finger		NAVICULAR VIEW		SOFT TISSUE STUDIES
	ACROMIO-CLAVICULAR JOINTS (W/WO WEIGHT)		FOOT		ORBITS		STERNUM
	ANKLE		HAND		OS CALCIS (HEEL)		TEMPORO-MANDIBULAR JOINTS
	CERVICAL SPINE		HIP		PELVIS		THORACIC SPINE
	CHEST PA / LATERAL		HUMERUS		RADIUS/ULNA		TIBIA/FIBULA
	COCCYX		KNEE		RIBS		TOES
	CONE DOWN SELLA TURCICA		LUMBAR SPINE		SACRO-ILLIAC JOINTS		WRIST
	ELBOW		MANDIBLE		SCAPULA		ZYGOMA
	FACIAL BONES		MAXILLA		SHOULDER		ZYGOMATIC ARCH
	FEMUR		NASAL BONES		SKULL		

REPORT

McDonald

LEFT MIDDLE FINGER: The fracture involving the tip of the distal phalanx of the finger is healing. There is some bony irregularity in the area but a definite fracture line is no longer seen.

D & T: 07-13-06 Howard P. Schiele, M.D./rr Board Certified Radiologist (Signature on file)

7/14/06

L Grantham 7-12-06

X-RAY TECHNOLOGIST'S NAME (PRINT) | X-RAY TECHNOLOGIST'S SIGNATURE | DATE, TIME EXAM PERFORMED

RADIOLOGIST'S NAME (PRINT) | RADIOLOGIST'S SIGNATURE | DATE SIGNED

AL DO Xray Gut 3rd

DEPARTMENT OF CORRECTIONS

8/3/06

RADIOLOGY SERVICES REQUEST AND REPORT

INSTITUTION: Elmore

Name: McDonald James

State ID No: 236354

DOB 3/22/68

Race: W Sex: M

NOTE: PERTINENT CLINICAL INFORMATION AND TENTATIVE DIAGNOSIS MUST BE PROVIDED FOR X-RAY EXAMINATION TO BE PERFORMED

Requesting Physician/PA/NP	Date of request	Time of request	Routine	Priority	Transportation or special needs
DR Darbey	6/26/06	10:45 Am			

HISTORY/DIAGNOSIS:

w/previous

X-RAY REQUEST

	ABDOMEN/KUB	L	FINGERS Middle		NAVICULAR VIEW		SOFT TISSUE STUDIES
	ACROMIO-CLAVICULAR JOINTS (W/WO WEIGHT)		FOOT		ORBITS		STERNUM
	ANKLE		HAND		OS CALCIS (HEEL)		TEMPORO-MANDIBULAR JOINTS
	CERVICAL SPINE		HIP		PELVIS		THORACIC SPINE
	CHEST PA / LATERAL		HUMERUS		RADIUS/ULNA		TIBIA/FIBULA
	COCCYX		KNEE		RIBS		TOES
	CONE DOWN SELLA TURCICA		LUMBAR SPINE		SACRO-ILIAC JOINTS		WRIST
	ELBOW		MANDIBLE		SCAPULA		ZYGOMA
	FACIAL BONES		MAXILLA		SHOULDER		ZYGOMATIC ARCH
	FEMUR		NASAL BONES		SKULL		

REPORT

McDonald

LEFT MIDDLE FINGER: The fracture involving the distal tuft is again noted. There is evidence of bony union but complete healing has not yet occurred.

IMPRESSION: HEALING FRACTURE, DISTAL PHALANX.

D & T: 07-05-06 Thomas J. Payne, III, M.D./rr Board Certified Radiologist (Signature on file)

7/6/06

X-RAY TECHNOLOGIST'S NAME (PRINT)

X-RAY TECHNOLOGIST'S SIGNATURE

7-3-06

DATE, TIME EXAM PERFORMED

RADIOLOGIST'S NAME (PRINT)

RADIOLOGIST'S SIGNATURE

AL DEPARTMENT OF CORRECTIONS

8B/06

RADIOLOGY SERVICES REQUEST AND REPORT

INSTITUTION: Easterling

Name: McDonald, James

State ID No: 236354

DOB 3/22/68

Race: W Sex: M

NOTE: PERTINENT CLINICAL INFORMATION AND TENTATIVE DIAGNOSIS MUST BE PROVIDED FOR X-RAY EXAMINATION TO BE PERFORMED

Requesting Physician/PA/NP	Date of request	Time of request	Routine	Priority	Transportation or special needs
Floyd/CRNP	6/26/06	11am	X		

HISTORY/DIAGNOSIS:

X-RAY REQUEST

	ABDOMEN/KUB	✓	FINGERS 3rd		NAVICULAR VIEW		SOFT TISSUE STUDIES
	ACROMIO-CLAVICULAR JOINTS (W/WO WEIGHT)		FOOT		ORBITS		STERNUM
	ANKLE	X	HAND Maurice H. Rowell		OS CALCIS (HEEL)		TEMPORO-MANDIBULAR JOINTS
	CERVICAL SPINE		HIP		PELVIS		THORACIC SPINE
	CHEST PA / LATERAL		HUMERUS		RADIUS/ULNA		TIBIA/FIBULA
	COCCYX		KNEE		RIBS		TOES
	CONE DOWN SELLA TURCICA		LUMBAR SPINE		SACRO-ILIAC JOINTS		WRIST
	ELBOW		MANDIBLE		SCAPULA		ZYGOMA
	FACIAL BONES		MAXILLA		SHOULDER		ZYGOMATIC ARCH
	FEMUR		NASAL BONES		SKULL		

REPORT

McDonald

LEFT 3RD DIGIT: There is a fracture involving the distal phalanx of the 3rd digit.

IMPRESSION: FRACTURE DISTAL PHALANX 3RD DIGIT.

D & T: 06-28-06 Maurice H. Rowell/dc Board Certified Radiologist (Signature on file)

6/29/06

X-RAY TECHNOLOGIST'S NAME (PRINT)

X-RAY TECHNOLOGIST'S SIGNATURE

6-27-06

DATE, TIME EXAM PERFORMED

RADIOLOGIST'S NAME (PRINT)

RADIOLOGIST'S SIGNATURE

DATE SIGNED

PHS
PRISON HEALTH SERVICES INCORPORATED

DEPARTMENT OF CORRECTIONS

DATE: 7/20/05

URINALYSIS

LEUKOCYTES	trace	BLOOD	neg
NITRITE	neg	SPEC. GRAVITY	1.010
UROBILINOGEN	normal	KETONE	small
PROTEIN	neg	GLUCOSE	normal
pH	6	HCG	—

med amber, mild odor

(Add: Final Labs Here)

7/20/05

INMATE NAME (LAST, FIRST, MIDDLE)	DOC #	DOB	RACE/SEX	FAC.
McDonald James	236354	3/22/68	W/M	ECF

PHS-MD-70012

LABORATORY REPORTS

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: James McDonald Date of Request: 10-19-04
ID # 236354 Date of Birth: 03-22-68 Location: G-2D
Nature of problem or request: I have a severe toothache in two teeth. Both need pulled. They have both been broken at the Gumline.

James McDonald
Signature

DO NOT WRITE BELOW THIS LINE

Date: 10/20/04
Time: 8:16 AM PM
Allergies: NKDA

RECEIVED
Date: 10-20-04
Time: 7:00a
Receiving Nurse Intials

(S)ubjective: Toothache * Wants Tooth Extracted

(O)bjective **(V/S):** **T:** **P:** **R:** **BP:** **WT:**

(A)ssessment:

(P)lan: RTC on Nov. 1, 2004 AT 9:00am

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE (✓) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

L. Mowdy DA
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF-1002 (1/4)

PRISON HEALTH SERVICES INCORPORATED

INTAKE HEALTH EVALUATION

NAME: McDonald, James
AIS #: 236354
D.O.B.: 3/22/68

Age 37 Sex M Race W Height 6'1 Weight 180

Temp: 96.5 B/P: 100/70 Pulse: 64 Resp: 16

** **B/P** – If greater than 140/90, repeat in 1 hour. Refer to Mid-Level if B/P remains up.

Do you now or have you ever had, or been treated for: FSBS 107

Problem	Y	N	Problem	Y	N	Problem	Y	N
Head Trauma	✓		Gastritis		✓	**HIV/AIDS** ***		✓
Loss of Consciousness	✓		Ulcers		✓	***Medications Verified		✓
Severe Headaches		✓	Bleeding		✓	Hepatitis - Type		✓
Vertigo/Dizziness	✓		Gall Bladder/Pancreas		✓	Gonorrhea		✓
Vision Problems	✓		Liver Problems		✓	Syphilis		✓
Hearing Problems		✓	Arthritis		✓	Lice, Crabs, Scabies		✓
Seizures		✓	Joint Muscle Problem		✓			
Strokes		✓	Back/Neck Problem		✓	**LMP**		
Nervous Disorders		✓	Kidney Stones/Dz		✓	Date		
DT's		✓	Bladder/Kidney Infection		✓	Duration		
Heart Condition		✓	Alcoholism		✓	Normal		
Angina/Heart Attack		✓	Drug Abuse		✓	Regularity		
High Blood Pressure		✓	Psychiatric History	✓		Gravida/Para		
Anemia/Blood Disorder		✓	Suicidal Thoughts**		✓	AB/Miscarriage		
Sickle Cell or Trait		✓	**Immediate M.H. Referral		✓	Contraception		
Lung Condition		✓	**T.B.**		✓	Type:		
Asthma *		✓	PPD - date given:					
*Peak Flow Reading		✓	RFA/LFA			**Lab Tests - Dates**	N	Ab
Bronchitis		✓	Date read:			Diagnostic Profile II		
Emphysema		✓	Results: mm			RPR		
Pneumonia		✓	**Visual Acuity**			Urine Dip Stick		
Diabetes		✓	**OD OS**					
Hay Fever/Allergies		✓	**OU** 20/20 c			**EKG** (@ age 35)		

Immunization History: States Current

Immunizations Needed: None

***HIV Medications: N/A

Acute or Chronic ~~Problem~~ Noted: Y N **Refer to Mid-Level or M.D. if yes.**

N Stroud LPN 9/15/04

RN or Mid-Level, Signature **Date/Time**

60511-AL C/O Prostate probl.

INTAKE HEALTH APPRAISAL

NAME:_____
AIS#:_____
D.O.B.:_____ **R/S**_____

HEALTH CLASSIFICATIONS:
(Circle One)

1 - No Restrictions

2 – Temporary Restrictions
See Special Needs Form
3 – Permanent Restrictions
See Special Needs Form
4 – A&I (Aged & Infirmed)

5 – Not Determined
Recheck_____.

PLACEMENT:

General Population (✓)
Emergency Department ( )
Isolation ( )
Medical Observation ( )
Other_____

REFERRAL:
CCC Placement ( )

Clinic(s)_____
See MD/Mid-Level flow sheet for clinic(s).
Medical ( )
Dental ( )
Mental Health ( )
Other_____
When: ( ) Immediately
( ) Next Sick Call

IMMUNIZATIONS ORDERED:

_____

_____

APPRAISAL		N	Abn/Comment
General Movement	Deformity Pain, Bleeding Habitus, Hygiene	/	
Neuro	Mental Status Intox Withdrawal, Tremor Neuro-Deficits	/	AA+O x3
Skin	Injury, Bruises, Trauma Jaundice Diaphoretic Rash, Lesions, Infestations Needle Marks Color, Turgor	/	Tatoos- multiple
Head	Normocaphalic Atraumatic Hair, Scalp	/	
Eyes	Glasses/Vision Pupils Sclera, Conjunctiva	/	20/20 OU CL
Ears	Appearance Canals, TMs, Hearing	/	
Nose	Epistaxis Sinuses	/	
Throat	Teeth, Gums, Dentures Mouth, Tongue, Tonsils Airway	/	
Neck	C-Spine, Mobility Veins, Carotids Thyroid, Lymph Nodes	/	Full ROM
Chest	Config. Ausc/Resp *Cough/Sputum* Breast/Masses	/	Resp C ease
Heart	Ausc Rate, Rhythm Murmurs, Ectopy	/	
Abdomen	Bowel Sounds Palp, G/R/T, Hernia	/	@ BB stools
GU	Flank Tenderness Bladder Tenderness/Distention	/	
Back	ROM, Spasm, Injury	/	Full ROM
Extremities	Edema, Pulse	/	MAEW
Genitals	Injuries/Lesions	/	Prost. problems
Pelvic Pap			
Rectal/Guiac (required @ 45 and up) **Deferred/follow-up:**			

Medications Ordered: _____

NP 9/17/04

M.D. or Mid-Level Signature **Date/Time**

ALABAMA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES

PSYCHIATRIC PROGRESS NOTES

DATE: 11/16/05 TIME:

Target Symptoms	Behavioral Rating Scale 0=No problem 5= worst	Today vs Before
Mood swings		0 / 0
Racing thoughts / increased energy		0 / 0
Pressured speech / anxiety		0 / 0
Impulsivity / Irritability		0 / 0
Poor sleep		0 / 0

Medications: Depakene, Xantac has been D/c'd as of 8/17/05. ✓ Informed Consent

Compliance: Inmate report % vs MAR % Doing well clinically.

In addition to the information in the tables above and below, then inmate-patient:

S "I have been doing well without taking any medicines for about three months now. I don't have any mood swings, I don't have any problem now." Reports ø other sxs of mood, anxiety or thought d/o. ø thoughts to hurt himself or anyone else. Voices no other concerns, A+Ox3

Side effects: **O**

Selected Issues	NO	YES	If yes, comment on pertinent positive findings
Psychosis	✓		ø sxs of psychosis, ø SI, ø HI, ø HA
Serious Depression	✓		ø sxs of depression or ø delusion
Self-Injurious Thoughts	✓		Denies | Bipolar D/o noted
Suicidal intent	✓		Denies ✓
Aggressive	✓		None noted
Seriously Impulsive	✓		None noted
Situational Upset	✓		None noted

Mood: euthymic
Affect: Approp
Thought Proces: logical

Lab info: None Labs Ordered: _____ Labs Reviewed: _____ AIMS:? _____

ASSESSMENT/Diagnosis (DSM-IV)

Bipolar D/o
(in remission)

PLAN: Im clinically stable without being on any psychotropic meds since 8/17/05. Exhibits ø sxs or signs of mental illness at this time. Discussed c Dx team to change his mental health code to H1ST.

Return to clinic: RTC PRN (Print) Last Name: DR - BANERJEE Sign: SBanerjee MD

Patient's Name: (Last, First, Middle)	AIS #	Age	R/S	Code	Institution
MCDONALD, JAMES	236354		W/M	~~H1ST~~ H1S	ECF

Disposition: Medical File

Discussed TX plan c Im. He understands and agrees c TX plan - RTC on PRN basis at this time. Continue care.

ADOC AR 632, 633, 623,615
ADOC Form MH-025 March 2, 2005

ALABAMA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES

PSYCHIATRIC PROGRESS NOTES

DATE: 8/17/05 TIME:

Target Symptoms — Behavioral Rating Scale 0=No problem 5= worst	Today vs Before
Mood swings	0/3
Racing thoughts / increased energy	0/2
Pressured Speech / Anxiety	0/0-1
Impulsivity / Irritability	0/1
Poor sleep.	0/1

Medications: med non-compliant VPA, Dekakene — Informed Consent ✓

Compliance: Inmate report 100% % vs MAR 100% %

In addition to the information in the tables above and below, then inmate-patient:

S "I am feeling fine. I don't want to take any more of the medicines. I am doing good without it." ◊ sx's of mood, anxiety or thought d/o. ◊ thoughts to hurt himself or anyone else. Voices no other issues or concerns.

Side effects: 0

A+Ox3. Good eye contact. Mood: euthymic Affect: Attributate Thought Process: Logical

Selected Issues	NO	YES	If yes, comment on pertinent positive findings
Psychosis	✓		◊ sx's of psychosis, ◊ SI, ◊ HI
Serious Depression	✓		◊ sx's of depression or Bipolar D/O
Self-Injurious Thoughts	✓		Denies
Suicidal intent	✓		Denies
Aggressive	✓		None noted
Seriously Impulsive	✓		None noted } at present time.
Situational Upset	✓		None noted

Lab info: Labs Ordered: None at this time. Labs Reviewed: VPA level was 55 ug/mL on 6/24/05 AIMS?

ASSESSMENT/Diagnosis (DSM-IV)

Bipolar D/O (in remission)

PLAN: Is clinically stable. Has been med non-compliant and refusing all psychotropic meds. at this time. Does not exhibit any sx's of mental illness. Will D/C Dekakene, DC Xanax. Will be followed up c RTC 90 days. Benefits counseling RTC in 90 days for follow up. Continue care.

Return to clinic: Print Last Name: DR. BANERJEE Sign:

Patient's Name: (Last, First, Middle)	AIS #	Age	R/S	Code	Institution/MD
MCDONALD, JAMES	236354		W/M	SMI	ECF

Disposition: Medical File

ADOC AR 632, 633, 623,615
ADOC Form MH-025 March 2, 2005

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 7-21-06

To: ADOC (Easterling)

From: PHS (Easterling)

Inmate Name: McDonald, James **ID#:** 236354

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other Bottom Bunk Profile x 6mth 7-21-06 → 1-2007

Comments:

Date: 7-21-06 **MD Signature:** V. SDR Durbow MD **Time:** 2p

James McDonald 60418

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 6/26/06

To: Doc

From: PHS

Inmate Name: McDonald James **ID#:** 23354

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Betadine Soaks qd to Middle D finger & Scrubbing to old dry blood Clot Removal - Dsg Dsg daily @ 5Pm x 1 week. 6/26/06 ~ 7/3/06

Date: 6/26/06 **MD Signature:** VO Floyd Cmr **Time:** 10:40 pm

60418

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 6/20/06

To: DOC

From: HCU

Inmate Name: McDonald, James **ID#:** 236354

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Dressing Δ to (L) middle finger BID - 5A, 5P until healed

Date: 6/20/06 **MD Signature:** Darbouze/ **Time:** 6:15pm

60418

X James McDonald

PHS
PRISON HEALTH SERVICES INCORPORATED

EMERGENCY

ADMISSION DATE 6/18/06 TIME 845 AM PM | ORIGINATING FACILITY Easterling ☐ SIR ☐ PDL ☐ ESCAPEE ☐ | ☐ SICK CALL ☐ EMERGENCY ☒ OUTPATIENT

ALLERGIES NKDA Wt: 155 | CONDITION ON ADMISSION ☒ GOOD ☐ FAIR ☐ POOR ☐ SHOCK ☐ HEMORRHAGE ☐ COMA

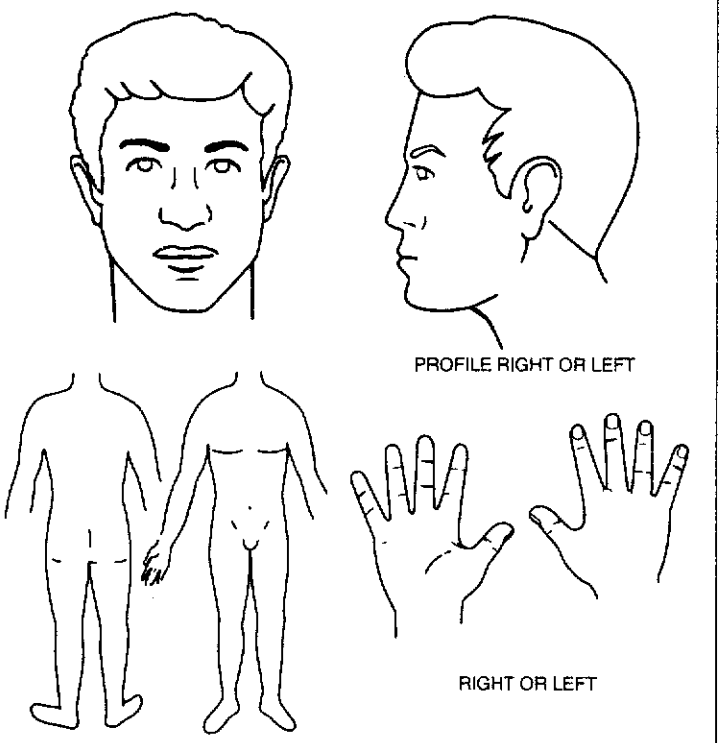
VITAL SIGNS: TEMP 97.8 ORAL RECTAL | RESP. 16 | PULSE 54 | B/P 100/50 | RECHECK IF SYSTOLIC <100> 50 ____/____

NATURE OF INJURY OR ILLNESS

S- "I cut my finger on a table saw in trade school"

O2Sat 98%

ABRASION ///	CONTUSION #	BURN xx xx	FRACTURE Z Z	LACERATION / ____ SUTURES



PHYSICAL EXAMINATION

O-W/m A+Ox3 Amb c Steady gait Resp c Lung Skin WD Laceration noted to (L) middle finger c/o feeling dizzy NAD noted Release to pop @ 945a c c complaints voiced.

A- Alt. in Skin integrity

P- Refer to MD

ORDERS / MEDICATIONS / IV FLUIDS	TIME	BY
Tetanus 0.5ml IM x 1		
Tylenol 1gm po NOW - Hold in hpn may for observation		

DIAGNOSIS

INSTRUCTIONS TO PATIENT

DISCHARGE DATE 6/18/06 TIME 945 AM PM | RELEASE / TRANSFERRED TO ☐ DOC ☐ AMBULANCE ☐ | CONDITION ON DISCHARGE ☒ SATISFACTORY ☐ FAIR ☐ POOR ☐ CRITICAL

NURSE'S SIGNATURE SBuchanan RN | DATE 6/18 | PHYSICIAN'S SIGNATURE | DATE 6/20/06 | CONSULTATION

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.
McDonald James	236354	3/22/68	W/m	ECF

INSTITUTIONAL EYE CARE

P.O. Box 390
Lewisburg, PA 17837
(570) 523-3493
FAX (570) 524-2817

PATIENT				DATE	
MC DONALD, JAMERS				2/13/2006	
NUMBER				INSTITUTION	
236354		DON		DONALDSON CORR FACILITY	
	SPHERE	CYLINDER	AXIS	PRISM	BASE
OD	-3.25	0.00	0	0	
OS	-4.00	-0.50	115	0	
	ADD	HEIGHT	DIST PD	NEAR PD	
OD	0.00	0	63	0	
OS	0.00	0	0	0	
LENS COLOR/COATINGS			Clear		
FRAME	NICK	STYLE		FRAME COLOR	
EYE SIZ	50	DROP BALL		FINAL INSPECTION	

LENSES:	$4.95
FRAME:	$3.49
OVERSIZE:	$0.00
TINT/PGX:	
POLYCARB:	$0.00
DIOPTERS:	$0.00
PRISM:	$0.00
CASE:	
OTHER:	
S/H:	$1.35
TOTAL DUE ($):	$9.79

- The continued impact resistance of your lenses depends on how well you protect them from physical shocks and abuse. For your own safety, they should be replaced immediately.

PHS
PRISON HEALTH SERVICES INCORPORATED

DEPARTMENT OF CORRECTIONS

RECEIPT OF MEDICAL EQUIPMENT/APPLIANCE FORM

I, James McDonald (Print Name) 8B104 (Doc#) 236354

acknowledge receipt of the following medical equipment or appliance:

( ) Splint
(X) Eyeglasses
( ) Dentures
( ) Prothesis describe _____
( ) Wheelchair
( ) Cane
( ) Crutches
( ) Other describe _____

I acknowledge that the equipment/appliance is functional for my use.

I also acknowledge the equipment/appliance is in good working condition.

James McDonald (Inmate) 3-27-06 (Date)

(Witness) 3/27/06 (Date)

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.
McDonald, James	236354			East

PHS-MD-70005 **(White – Medical File, Yellow – Security Property Officer)**

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 1-9-06

To: Doc

From: PHS

Inmate Name: McDonald James **ID#:** 236354

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Bottom Bunk Profile x 6mo

1-9 06 → ~~1-9-06 7-9-06~~ 7-9-06

Date: 1-9-06 **MD Signature:** VO Dr Dalbourne/Pharm **Time:** 9 AM

60418

James McDonald

PHS
PRISON HEALTH SERVICES INCORPORATED

RELEASE OF RESPONSIBILITY

Inmate's Name: James D. McDonald 236354

Date of Birth: 3-22-68 Social Security No.: 549-39-8314

Date: 11-22-05 Time: 8:25 AM (A.M.) P.M.

This is to certify that I, James P. McDonald (Print Inmate's Name), currently in custody at the Easterling Correctional Center (Print Facility's Name), am refusing to accept the following treatment/recommendations: Hepatitus B Vaccine (Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

James P. McDonald 236354
(Signature of Inmate)**

SPOUSE LPN
(Signature of Medical Person)

Yolanda Lora
(Witness)

(Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

60115 (5/85)

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 10/15/05

To: DOC - Easterling

From: HCU - Easterling

Inmate Name: McDonald, James **ID#:** 236354

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Report to HCU on Monday 10/17/05 at 1630 am for PPD reading.

Date: 10/15/05 **MD Signature:** VO Dr. Darbouze **Time:** 835am

X James McDonald

60418

Prison Health Services

REFUSAL OF TREATMENT FORM

Institution: Easterling

Resident's Name: McDonald James ID# 236354

D.O.B. 3-22-68

I, Jame McDonald (Name of Inmate) have, this day, knowing that I have a condition requiring medical care as indicated below:

✓	A.	Refused medication.	___	E.	Refused X-Ray services.
___	B.	Refused dental care.	___	F.	Refused other diagnostic tests.
___	C.	Refused an outside medical appointment.	___	G.	Refused physical examination.
___	D.	Refused laboratory services.	✓	H.	Other (Please specify) Chronic Care

Reason For Refusal I Don't feel it is what I need.

Potential Consequences Explained Informed Pt of what med was used for & dangers that could occur 5 med. usage Voices understanding

I acknowledge that I have been fully informed of and understand the above treatment recommendations and the risks involved in refusing them. I hereby release and agree to hold harmless the state, statutory authority, all correctional personnel, medical/health personnel from all responsibility and any ill effects which may result from this refusal and I shall personally assume responsibility for my welfare.

I have read this form and certify that I understand its contents.

Witness Signature

Witness Signature

8-18-05
Date

Patient Signature

8-18-05
Time

NOTE: A refusal by the resident to sign requires the signatures of at least one witness in addition to that of the medical staff member.

PHS MD-70108

PHS
PRISON HEALTH SERVICES INCORPORATED

RELEASE OF RESPONSIBILITY

Inmate's Name: James McDonald

Date of Birth: 3-22-68 Social Security No.: 236354

Date: 7-24-2005 Time: 10 20 A.M. (P.M.)

This is to certify that I, James McDonald (Print Inmate's Name), currently in custody at the Elmore (Print Facility's Name), am refusing to accept the following treatment/recommendations: NO Show S/C 7-24-2005 (Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

(Signature of Inmate)**

(Signature of Medical Person)

(Witness)

(Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

60115 (5/85)

PRISON HEALTH SERVICES INCORPORATED

DEPARTMENT OF CORRECTIONS

KITCHEN CLEARANCE PHYSICAL ASSESMENT

	YES	NO
ANY OPEN SORES OR RASHES ON HANDS, ARMS, FACE & NECK		✓
TB TEST CURRENT	✓	
DOES PT. SHOW ANY OBVIOUS SIGNS OF ANY OTHER DISEASE		✓

OTHER: _____

THIS PATIENT HAS BEEN INFORMED OF THE NEED FOR THE FOLLOWING:

PROPER HANDWASHING, NOT TO HANDLE FOOD WHILE SICK, SEEK MEDICAL EVALUATION WHEN NECESSARY AND TO NOTIFY THE DIETARY SERVICES SHIFT SUPERVISOR OF ANY ILLNESS.

MEDICAL AUTHORITY: SMcKinnon DATE: 12/4/04

I attest that the above statement is true to the best of my knowledge.
PATIENT SIGNATURE: James McDonald DATE: 12-4-04

EXPIRATION DATE: 12/4/05

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	Race/Sex	FAC.
McDonald, James	236354	3/22/68	W/M	Ent

PHS-MD-70042 **(White - Medical File, Yellow - Kitchen Supervisor, Pink - Classification Administrator (Inmate))**